

November 25, 2019

Proposed Regulations
Minimum Standards for Veterinary Telemedicine: OAR 875-015-0035

Emilio DeBess, DVM, MPH
Chair, Oregon Veterinary Medical Examining Board
800 NE Oregon St., Suite 407
Portland OR 97202

Dear Dr. DeBess and Board Members:

When the Oregon Veterinary Medical Examining Board (OVMEB) initially proposed rules for Veterinary Telemedicine (VTM) in 2018 (1/23/2018 filing), the Oregon Veterinary Medical Association (OVMA) was fully supportive. This original filing relied on 2018 positions of both the AVMA and AAVSB which supported VTM only in the context of a valid and traditional Veterinarian-Client-Patient Relationship (VCPR)¹ and by a person with a valid license to practice veterinary medicine in the state in which VTM services were received (see 875-005-0005 (14) and (19) of that previous filing). The newly proposed amendment for minimum standards of VTM (875-015-0035) removes both the explicit requirement for Oregon licensure and changes the definition of VCPR—in this proposed amendment, VCPR is suggested to possible even in the absence of physical exam if the veterinarian has reviewed medical records and deems diagnosis and treatment possible from those records (hereafter referred to as “virtual” rather than “traditional” VCPR).

We are deeply skeptical that provision of care outside of the traditional VCPR will benefit animal welfare, public health, or consumers. In human medicine, virtual care in the absence of a traditional physician-patient relationship has presented cost, antibiotic stewardship and quality issues even with strict guidelines for telepractice². Studies comparing performance of direct-to-consumer (DTC) telemedicine

¹ The AVMA has maintained its policy that telehealth consultations should only within the context of a valid and traditional VCPR; The AAVMB, in their recent proposed model policy for telemedicine suggests that it may be possible for telemedicine to occur in the absence of traditional VCPR but only if the veterinarian has “sufficient knowledge” of the animal to initiate a general or preliminary diagnosis and is readily available for follow-up care; the AAVMB recommends that states formulate policy on what constitutes “sufficient” knowledge.

² Krupinski, Elizabeth A., and Jordana Bernard. “Standards and Guidelines in Telemedicine and Telehealth.” *Healthcare* 2, no. 1 (March 2014): 74. <https://doi.org/10.3390/healthcare2010074>.

versus traditional care have found excessive antibiotic prescribing³, lower diagnostic performance^{4,5} and increased overall costs⁶. Traditional VCPR is claimed to be a barrier for access to care by animal owners without a veterinarian (“non-clients”) that, if replaced by virtual DTC care, will result in much greater uptake of veterinary services and increase animal access to medical care⁷. This has not been the case in human telemedicine where utilizers of DTC telemedicine are not disproportionately underserved by traditional physician practice⁸ and may be from higher income strata⁹.

Proponents of veterinary telemedicine as a primary care delivery modality (DTC) outside of a traditional VCPR contend that electronic sensing equipment is sufficiently developed to replace the traditional physical exam¹⁰. The current level of technology does not warrant this assertion—current remote sensing capacity in veterinary medicine is de minimus¹¹. Moreover, review of medical records is insufficient for preliminary diagnosis and treatment recommendations for any new onset problem, nor would record review alone be considered adequate as a second opinion for a pre-existing problem. Most preventative care cannot be performed remotely. Physical exam¹² remains a cornerstone of patient assessment in clinical veterinary practice and is explicitly or implicitly required in most clinical practice guidelines; we doubt that any of the AVMA-recognized clinical specialty boards would regard diagnosis or treatment in the absence of a traditional VCPR acceptable by their current standards. A recent survey of RCVS practitioners found that a majority of respondents viewed offering specific diagnostic, treatment, or

³ Uscher-Pines, Lori, Andrew Mulcahy, David Cowling, Gerald Hunter, Rachel Burns, and Ateev Mehrotra. “Access and Quality of Care in Direct-to-Consumer Telemedicine.” *Telemed. J. E. Health*. 22, no. 4 (April 2016): 282–287. <https://doi.org/10.1089/tmj.2015.0079>. and

Ray, Kristin N., Zhuo Shi, Courtney A. Gidengil, Sabrina J. Poon, Lori Uscher-Pines, and Ateev Mehrotra. “Antibiotic Prescribing During Pediatric Direct-to-Consumer Telemedicine Visits.” *Pediatrics* 143 (May 2019): 5. <https://doi.org/10.1542/peds.2018-2491>.

⁴ Resneck, Jack S., Michael Abrouk, Meredith Steuer, Andrew Tam, Adam Yen, Ivy Lee, Carrie L. Kovarik, and Karen E. Edison. “Choice, Transparency, Coordination, and Quality Among Direct-to-Consumer Telemedicine Websites and Apps Treating Skin Disease.” *JAMA Dermatol*. 152, no. 7 (July 2016): 768–775. <https://doi.org/10.1001/jamadermatol.2016.1774>.

⁵ Uscher-Pines, Lori, Andrew Mulcahy, David Cowling, Gerald Hunter, Rachel Burns, and Ateev Mehrotra. “Access and Quality of Care in Direct-to-Consumer Telemedicine.” *Telemed. J. E. Health*. 22, no. 4 (April 2016): 282–287. <https://doi.org/10.1089/tmj.2015.0079>.

⁶ Ashwood, J. Scott, Ateev Mehrotra, David Cowling, and Lori Uscher-Pines. “Direct-To-Consumer Telehealth May Increase Access To Care But Does Not Decrease Spending.” *Health Aff. (Millwood)*. 36, no. 3 (March 2017): 485–491. <https://doi.org/10.1377/hlthaff.2016.1130>.

⁷ <https://todaysveterinarypractice.com/navc-keynote-commentary-veterinary-community-regulatory-road-map-telehealth-pet-health-care/>

⁸ Uscher-Pines, Lori, Andrew Mulcahy, David Cowling, Gerald Hunter, Rachel Burns, and Ateev Mehrotra. “Access and Quality of Care in Direct-to-Consumer Telemedicine.” *Telemed. J. E. Health*. 22, no. 4 (April 2016): 282–287. <https://doi.org/10.1089/tmj.2015.0079>. and

⁹ Jung, C., R. Padman, G. Shevchik, and S. Paone. “Who Are Portal Users vs. Early e-Visit Adopters? A Preliminary Analysis.” *AMIA Annu. Symp. Proc.* AMIA, no. Annu (October 2011): Symp.

¹⁰ https://navc.com/download/2017_VIC_Guiding_Principles.pdf

¹¹ accelerometry, RFID, and cardiac sensors are currently available remote sensing technologies.

¹² Herd visit in the case of production medicine

prescription advice based on solely on virtual consultation as a high risk or inappropriate activity¹³. Additionally, there is good evidence that physical examination in the context of routine preventative visits identifies medical problems that a majority of owners were previously unaware of¹⁴.

The Federation of State Medical Boards (FSB) Model Policy for Appropriate Use of Teletechnologies in the Practice of Medicine requires that for telepractice, the physician is assesses the *current* status of the patient, is held to an external *standard of care*, obtains informed consent, is subject to oversight by the state medical board, and guards against potential financial conflicts of interest around prescribing¹⁵. The Oregon Medical Board has incorporated these concepts into their general administrative rules (847-025-0000) and their general statement of Telemedicine Philosophy¹⁶.

We think it vital that if any non-traditional VCPR telemedicine is allowed by OVMEB, these additional protections and criteria for quality should be considered. Of particular concern are criteria for determining sufficient knowledge according to standard of care and what non-VCPR VTM provider responsibilities are for treatments, follow-up and/or further diagnostic workup if recommended. The Colorado State Veterinary Board has used the FSB template for their guideline for appropriate use of telehealth technologies (attached) that contains additional language and definitions to provide more robust consumer protection: “*sufficient knowledge of the animal*” requires a traditional VCPR to engage in telemedicine practice in Colorado. We think that Colorado’s policy should be considered for adoption until more is known regarding telemedicine outside traditional VCPR.

Telemedicine is an important and valuable tool of which the profession has availed itself for many years. VTM provides us with more ways to care for our patients. But we believe that VTM should only be utilized within the context of a traditional VCPR pending additional research on the effects of virtual (DTC) veterinary telemedicine on quality of care, costs, and accessibility for animal owners in Oregon:

1. Will virtual veterinary telemedicine result in injudicious antibiotic prescribing, particularly in food animals? According to the proposed rule, review of herd health visit records would be sufficient to prescribe medically important antibiotics without a visit to premises. This runs counter to the profession’s concerted effort to limit antibiotic use. Shall a virtual veterinarian be allowed to prescribe cytotoxic or controlled drugs without a physical exam?
2. Is the quality of telemedicine care delivered by a virtual vet comparable to the quality of care delivered using traditional VCPR?
3. How would the overall cost of veterinary care for animals be effected by the entrance of virtual vet telemedicine entrants? Would this improve accessibility and decrease costs as predicted by its lobbyists or will it have similar effects as to what has been seen with DTC in human medicine? Many small animal practitioners might predict cost increases: the practice of telemedicine in the context of VCPR already occurs frequently in this state with clients sending videos, photos, and

¹³ <https://www.rcvs.org.uk/document-library/telemedicine-consultation-summary/>

¹⁴ Robinson, N. J., M. L. Brennan, M. Cobb, and R. S. Dean. “Investigating Preventive-Medicine Consultations in First-Opinion Small-Animal Practice in the United Kingdom Using Direct Observation.” *Preventive Veterinary Medicine* 124 (February 1, 2016): 69–77. <https://doi.org/10.1016/j.prevetmed.2015.12.010>.

¹⁵ https://www.fsmb.org/siteassets/advocacy/policies/fsmb_telemedicine_policy.pdf

¹⁶ <https://www.oregon.gov/omb/board/philosophy/Pages/Telemedicine.aspx>

email descriptions—frequently a diagnosis is not possible with these materials and an examination must be performed to clarify the problem. Will monetized virtual veterinary care result in one fee for a recommendation for an exam, followed by a second fee for the needed exam?

4. How would virtual veterinary care affect availability of veterinary services in rural communities? Brick and mortar veterinary practices have significantly higher overhead than virtual care; there is a potential to disrupt and displace traditional practices leading to lower availability of hospital/emergency services in these areas¹⁷. Unlike human healthcare, where there is governmental support for rural hospitals and medically underserved areas, veterinarians in remote areas are not supported by any revenue other than practice income.
5. What standard of care will be used to determine whether a practitioner has sufficient knowledge to diagnose and treat in the absence of a physical exam? Human medicine has defined standards of care which are applied to the practice of telemedicine (for example, see attached standards for pediatric telemedicine operating procedures). What standards shall be applied to veterinary telemedicine to safeguard patient care?
6. What separation between prescribing and dispensing shall exist for virtual veterinarians? Should they be employed by pharmacies? Will they have the same obligation to prescribe to the pharmacy of the consumer's choice as Oregon licensees have?
7. What data and privacy protections will be applied to the practice of telemedicine? Our profession already faces challenges with practice management software systems data-harvesting TOS in violation of confidentiality rules of many state boards¹⁸.

We believe these are critical questions to answer prior to changing definitions of VCPR for the purpose of allowing virtual vet telemedicine and propose that the OVMEB adopt the framework used by the Colorado State Board pending clarification on the questions above. If a virtual VCPR is allowed, then definitions, conflict of interest, data protections, safe prescribing, and external criteria for standards of care should be carefully considered and we suggest forming a task force comprised of representatives from clinical specialty colleges, the Oregon State Carlson College of Veterinary Medicine clinical sciences faculty, and general practitioners to consider the framework and implications of such a rule change.

We appreciate your time in discussing this important topic and in presenting the proposed rules on VTM. We also ask that you take into consideration our suggestions for modifying the proposal. Thank you.

Sincerely,

CN White

Constance N. White, DVM MPH, PhD
President

¹⁷ <https://news.vin.com/vinnews.aspx?articleId=54736>

¹⁸ <https://news.vin.com/vinnews.aspx?articleId=51953>

